



Department of Health Care Policy and Financing  
Children's Basic Health Plan

FY 2016-17, FY 2017-18, and FY 2018-19 Budget Request

**February 2017**

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## **CHILDREN'S BASIC HEALTH PLAN**

The following is a description of the budget projection for the Children's Basic Health Plan.

### ***Points of Interest***

- Beginning in January 2013, Medicaid eligibility expanded to include children ages 6 to 18 up to 133% Federal Poverty Level (FPL) per SB 11-008 and prenatal clients up to 185% FPL per SB 11-250. Senate bills 11-008 and 11-250 led to a significant decrease in caseload for CHP+ and the effects were previously reported as bottom line adjustments in caseload.
- The Modified Adjusted Gross Income (MAGI), required by the Affordable Care Act of 2010 (ACA) began in October 2013. States are required to use this new income and a standardized household size definition to determine eligibility for low-income subsidies in Health Care Exchanges, as well as Medicaid and federal CHIP programs. The changes from the implementation of MAGI were previously reported as bottom line adjustments and are now considered a part of the base caseload. As expected, the implementation of MAGI has resulted in a decrease in caseload.
- Continuous eligibility was implemented for Medicaid Eligible Children and CHP+ Children in March 2014 and the Department has experienced increased growth as a result.
- Beginning in January 2013, systems issues created duplicate payments for CHP+ clients in the State Managed Care Network. The magnitude of these duplication errors has waned considerably.
- In FY 2013-14, prenatal capitations for some clients within 201%-260% FPL experienced systems issues. The issues have been tied to individual income rating codes that represent the following FPL brackets: 185%-200%, 201%-213%, and 214%-225%. This issue was resolved in FY 2014-15.
- After January 2014, an income rating code used to identify clients from 201%-205% changed to 201%-213% as part of the MAGI conversion. Clients under 205% FPL receive funding from the CHP Trust Fund while clients over 205% FPL receive funding from the Hospital Provider Fee (HB 09-1293). The Department is working to identify a discrete FPL for all CHP+ clients, but until that option is available a distribution of clients over 200% FPL prior to January 2014 is being used to estimate the clients that are between 201%-205% and 206%-260% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.
- The contracted rates for prenatal clients in FY 2016-17 are unchanged from the contracted rates in FY 2014-15.
- In FY 2013-14, a budget amendment was passed to expand dental services in CHP+ in order to bring the program into compliance with the CHIPRA Legislation of 2009. This has resulted in a substantial increase in rates for dental services in FY 2014-15.

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- In FY 2014-15, the Department had submitted an estimate for the implementation of HB 09-1353, removing the five-year bar on legal immigrant children and pregnant women. The five-year bar had been removed for Medicaid eligible pregnant adults, but not for Medicaid Eligible Children and CHP+ clients. The policy was implemented in FY 2015-16.
- The Department began paying a disallowance in FY 2014-15 due to the expiration of the prenatal waiver used to pay for prenatal clients within the 206%-260% FPL range. Payment details can be found on page R-3.C2-6.

### ***History and Background Information***

Children's Basic Health Plan (CBHP), also known as Children's Health Plan *Plus* (CHP+), provides affordable health insurance to children under the age of 19 and pregnant women in low-income families (up to 260% of the federal poverty level) who do not qualify for Medicaid and do not have private insurance. CHP+ offers a defined benefit package that uses privatized administration.

The federal government implemented this program in 1997, giving states an enhanced match on state expenditures for the program. Colorado began serving children in April of 1998. Where available, children enroll in a health maintenance organization. CHP+ also has an extensive self-insured managed care network that provides services to children until they enroll in a selected health maintenance organization, and to those children who do not have geographic access to a health maintenance organization. All pregnant women enrolled in CHP+ receive services through the State's self-funded network.

The number of CHP+ enrollees and their per capita costs fluctuate due to changes in economic conditions, federal and state policies, and a number of other factors, resulting in changes in CHP+ program expenditures. Changes in funding from sources such as the Tobacco Master Settlement Agreement and Tobacco Taxes also increase the volatility in funding needs. Thus, the Department periodically updates its caseload and expenditure forecast based on recent experience and submits funding requests to the General Assembly. This ensures that the Department has sufficient spending authority to cover expenditures for CHP+ clients and the program's administration.

The eligible CHP+ populations are:

- Children to 205% FPL (Medical and Dental)
- Children 206%-260% FPL (Medical and Dental)
- Prenatal to 205% FPL
- Prenatal 206%-260% FPL

## **CBHP CAPITATION PAYMENTS**

The CBHP Capitation Payments line item reflects the appropriation that funds CBHP services throughout Colorado through managed care providers contracted by the Department. CHP+ children are served by either a health maintenance organization (HMO) at a fixed monthly cost, or by the State's managed care network (SMCN), which is administered by a no-risk provider. Actual and estimated caseload ratios between HMOs and the self-funded network are used to develop blended capitation rates and per capita costs. All clients in the prenatal program are served by the self-funded program (SMCN) administered by Colorado Access and the costs of their services are billed in full directly to the State.

The CHP+ Third Party Administrator (TPA) contract was re-bid for FY 2008-09, and Colorado Access was selected as the new vendor.

The dental vendor contract was re-bid for FY 2007-08, and a new contract was executed with Delta Dental. As part of the re-bid process, Delta Dental was able to offer an increased benefits package. These changes included increasing the cap on dental benefits from \$500 to \$600 per year, removing the age limit on sealants and fluoride varnishes, and increasing the cap on fluoride varnishes from one to two per year. In FY 2013-14, there was a budget amendment passed (BA-11) to align the CHP+ oral health care benefits with the CHIPRA legislation of 2009. CHP+ dental coverage had been lacking periodontics care, orthodontic care, prosthodontic care, and the required coverage of all medically necessary oral health care. Such services were added to the scope of coverage and the dental program's annual maximum was increased from \$600 to \$1000. These changes in the oral health care benefits led to significant increases in the dental rates for FY 2014-15.

Effective July 1, 2010, the Department implemented a new reimbursement schedule for inpatient hospital payments and effective October 31, 2016 implemented a new reimbursement schedule for outpatient hospital payments. The Department is now using the Colorado Medicaid Diagnosis Related Groups (DRGs) for inpatient services and the Colorado Medicaid Enhanced Ambulatory Patient Groups (EAPGs) for outpatient services.

### ***Analysis of Historical Expenditure Allocations across Eligibility Categories***

Historical expenditure allocations across eligibility categories reflects the expenditures reported in the Colorado Financial Reporting System (COFRS). Beginning July 1, 2014, the Department transitioned from COFRS to Colorado Operations Resource Engine (CORE). Historical expenditure through FY 2013-14 is from COFRS and historical expenditure from FY 2014-15 and ongoing is from CORE.

***Description of Transition to New Methodology***

As part of its ongoing efforts to continuously improve the projections, as well as to provide access to information more specific than overall per-capita rates, the Department has moved to a capitation trend forecast model beginning with the FY 2014-15 Request. In short, the methodology examines the trend in capitation rates across each eligibility category and applies that trend to the average per-claim, incurred expense rate. By examining the capitation rate trends for each eligibility category, rather than a weighted rate for all categories, future expenditures are forecasted per the characteristics of a specific eligibility category: the actuarially agreed-upon capitation rate and caseload for the nine categories rather than the previous three (children's medical, children's dental, and prenatal). In addition to viewing the nine eligibility categories separately, the Department has divided up the categories further to analyze each group that has a specific rate. This grouping separates by age as well as FPL. The different age groups apply only to children: 0-1, 2-5, and 6-18. The same FPL brackets apply to both children and prenatal: under 100%, 101%-150%, 151%-200%, 201%-205%, and 206%-260%. These individual analyses are then aggregated in the FPL brackets 0%-205% and 206%-260%. The age groups are each considered separately. By tying forecasted capitation rates directly to each category, the methodology may provide more accurate estimates of expenditures by eligibility category as well as provide an additional window of transparency into the forecasting process by presenting a clear link between total expenditure and the rates being paid to health maintenance organizations and the state managed care network.

In estimating the future per capita costs, the Department has also started incorporating claims distribution and retroactivity adjustments to the projected rates beginning with the November 2013 request. The adjustments are described in further detail in Exhibit C8 (page R-3.12)

Additionally, the Department has incorporated an incurred but not reported methodology similar to the Medicaid Behavioral Health Program Request submitted by the Department. The Department is adjusting its request to capture the reality that some CBHP claims incurred in any one fiscal year may not be paid during that same fiscal year. Similarly, some portion of expenditure in any fiscal year will be payments on claims incurred in prior fiscal years.

The following narrative describes in greater detail the assumptions and calculations used in developing the current year and out-year for the Children's Basic Health Plan. It should be noted that the data and values in many of the exhibits are contained and/or calculated in one or more other exhibits which may come before or after the exhibit being described. When this occurs, the source exhibit will be noted.

**EXHIBIT C1 - CALCULATION OF CURRENT TOTAL LONG BILL GROUP IMPACT**

Effective with the November 1, 2013 Budget Request, the Department includes Exhibit C1 which presents a concise summary of spending authority affecting Children's Basic Health Plan. In this exhibit the Department sums the total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department. The total spending authority is compared to the total projected current year expenditures from Exhibit C2. The difference between the two figures is the Department's Supplemental Request for the current fiscal year.

For the request year, the Department starts with the prior year's appropriation including special bills and adds in any required annualizations. This total is the Base Amount for the Request year. The total Base Amount is compared to the total projected request year expenditure from exhibit C2 (pages S-3A, BA-3.C2-1 through S-3A, BA-3.C2-3). The difference between the two figures is the Department's Funding Request in the November Budget Request and the Department's Budget Amendment in the February Supplemental Budget Request.

**EXHIBIT C2 - CALCULATION OF FUND SPLITS**

Exhibit C2 details fund splits for all Children's Basic Health Plan budget lines for the current fiscal year Supplemental and the out-year Budget Request. Capitation expenditures are split between traditional clients and expansion clients. The State share for the traditional clients (0%-205% FPL) is funded from the CBHP Trust fund and the State share for expansion clients (206%-260% FPL) is funded from Hospital Provider Fee funds (HB 09-1293).

The Patient Protection and Affordable Care Act (Sec. 2101 (a)) enhanced the CHP+ FMAP 23 percentage points beginning October 1, 2015 through September 30, 2019 (SSA 2105 (b)). The average for the State Fiscal Year 2016-17 was 88.13%. The projected FMAP for FY 2017-18 is 88.00% and the projected FMAP for FY 2018-19 is 88.00%. Due to this 23 percentage point increase, the Department forecasts that the CBHP Trust Fund will be sufficient for the State share of CHP+ expenditures beginning in FY 2015-16 and ongoing. The total amount attributed to the General Fund in FY 2016-17 and FY 2017-18 is due to the disallowance payments, discussed above. The Department is also expecting to recover payments in FY 2016-17 for prior year dates of service. Due to state fiscal rules, the Department is unable to offset current year expenditure for prior year recoveries, and therefore, the recoveries are counted as revenue to cash funds.

**EXHIBIT C3 - CHILDREN'S BASIC HEALTH PLAN SUMMARY**

Exhibit C3 presents a summary of Children's Basic Health Plan caseload and capitation expenditures itemized by eligibility category and a summary of the bottom line adjustments to expenditure, as well as expenditures for CBHP Administration. The net capitation payments include the impacts of the reconciliations for manual enrollments. Exhibit C6 illustrates the build to the final expenditure estimates presented in this exhibit.

**EXHIBIT C4 - CBHP CASELOAD**

Exhibit C4 contains the caseload history for each of the eligibility categories broken down by poverty level (0%-205% and 206%-260%) and also broken down by age group for children's categories (ages 0-1, 2-5, and 6-18). Each of the tables that comprise Exhibit C4 is described below. Forecast details for CHP+ caseload can be found starting on page S-3A, BA-3.22 of this narrative.

*Children's Basic Health Plan Caseload by Fiscal Year*

Caseload for the Children's Basic Health Plan is displayed in one table showing caseload by all CHP+ eligibility categories. Figures for fiscal years up to the present fiscal year are actual caseloads, while the current fiscal year and the request year caseloads are estimates. The caseload numbers are used in numerous exhibits throughout the Children's Basic Health Plan Exhibits and narrative. Caseload numbers for children are used twice, once for medical and once for dental.

Caseload forecast by fiscal year shows the final estimated caseload, caseload adjustments, and base caseload. Caseload adjustments in this request include the estimates for the implementation of HB 09-1353 (which removes the 5 year bar on legal immigrant children and pregnant women).

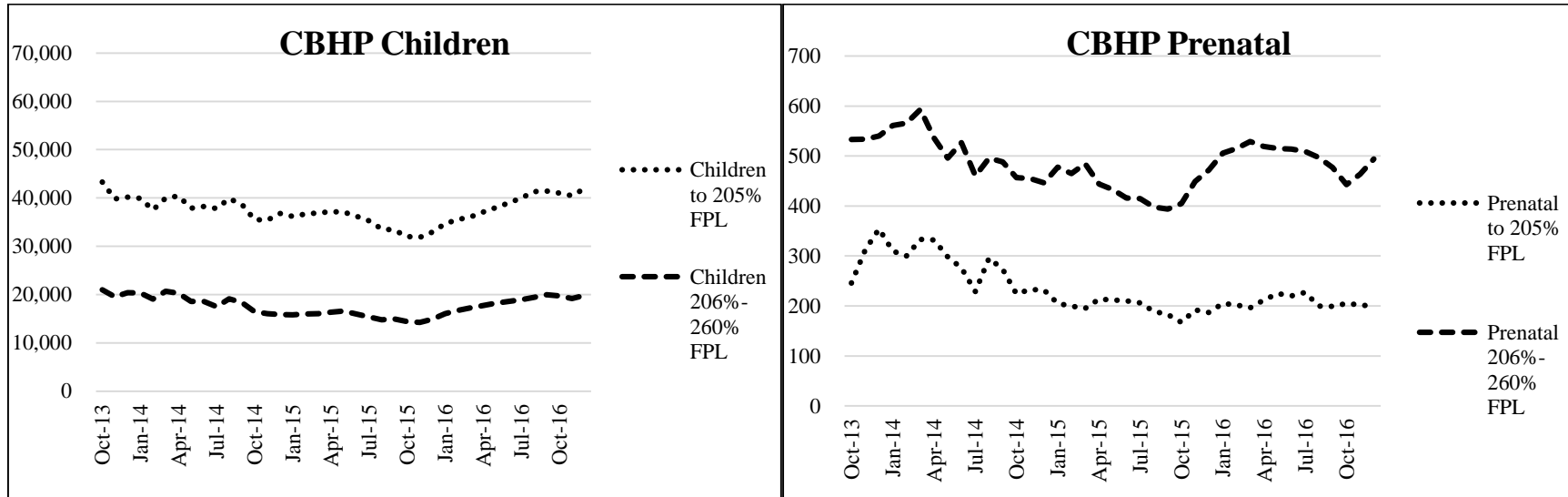
*Children's Basic Health Plan Caseload by Month*

These tables show the actual caseload by month as reported in the JBC monthly report for the three most recent fiscal years. The data in this table is what the Department uses to forecast monthly caseload. The Department experienced variance between MMIS and CMBS numbers for the first half of FY 2015-16, but the data normalized back to historical levels in the second half of the year. The variance no longer seems to be a concern.

As can be seen in the graphs shown below and on page S-3A, BA-3.C4-5, From January 2013 to January 2014 caseload decreased steadily for populations under 205% FPL, due to the implementation of SB 11-008 and SB 11-250 and the MAGI conversion, and

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increasing for populations above 205% FPL. The most recent months (January 2014 – December 2016) seem to have remained relatively steady.



### *Children's Basic Health Plan Per Capita Historical Summary*

Children's Basic Health Plan per capita is displayed in one table. The table displays per capita by all CBHP eligibility categories; children categories are displayed twice to show medical and dental per capita. Figures for fiscal years up to the present fiscal year are actual per capita, while the current fiscal year and the request year per capita are estimates. Calculated per capita in Exhibit C4-Per Capita Historical Summary represent the estimated per capita including all expenditure adjustments for the given fiscal year. Forecasted per capita without bottom line adjustments can be found in exhibit C6, pages S-3A, BA-3.C6-1 through S-3A, BA-3.C6-3. Calculations are described in exhibits C6 through C10 (pages S-3A, BA-3.10 through S-3A, BA-3.16).

### *Children's Basic Health Plan Historical Expenditures Summary*

The history of expenditures shows total capitation expenditures for all CBHP eligibility categories. Medical and dental expenditures are listed separately. Actual expenditures through FY 2013-14 by eligibility category are available from the Colorado Financial Reporting System (COFRS) and actual expenditures for FY 2013-14 are also reported in exhibit C3-Expenditure Summary, page S-3A, BA-3.C3-

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1. Actual expenditure from FY 2014-15 and forward are from the Colorado Operations Resource Engine (CORE). This exhibit also includes a similar summary of expenditure for all forecast years.

### **EXHIBIT C5 - CHILDREN'S BASIC HEALTH PLAN FUNDING SOURCES**

#### *Traditional Population Expenditures and Funding*

This exhibit shows expenditures for the traditional population in isolation and provides additional detail to the calculation of fund splits. Traditional populations include those from 0%-205% FPL. These populations receive the enhanced CHP+ Federal Match and receive cash funds from the CHP Trust Fund, CO Immunization Fund, and Health Care Expansion Fund. Once the available cash funds have been used, the General Fund covers the remaining State share of expenditures for clients under 205% FPL. The available funding from the CHP Trust Fund and the CO Immunization Fund is forecasted using the published projections in the 2017 Tobacco MSA Payment Forecast, allocation changes from HB 16-1408 "Cash Fund Allocations for Health-related Programs", and the actual expenditures from prior years. Calculations can be seen in exhibit C5, page S-3A, BA-3.C5-2.

As described above for exhibit C2, the CHP+ Federal Match increases by 23 percentage points in October 2015. After this increased match, the Department forecasts that the CHP Trust Fund will have sufficient revenue to cover the expenditures of the CHP+ population under 205% FPL. This results in \$0 General Fund expenditure for capitation payments. These calculations are shown on page S-3A, BA-3.C5-2.

#### *Expansion Population Expenditures and Funding*

HB 09-1293 established a funding mechanism for a series of expansion clients. The set of expansion clients that are funded through the bill are children and prenatal clients with income 206%-260% FPL. These populations also receive the enhanced CHP+ Federal Match. Services for these clients are funded through the Hospital Provider Fee Cash Fund. This exhibit shows expenditures for the expansion population in isolation and provides additional detail to the calculation of fund splits.

#### *Children's Health Plan Plus Enrollment Fees*

Clients above 157% FPL owe an enrollment fee prior to accessing benefits. There is a fee for enrolling either one child, or more than one child. This exhibit shows the assumptions and calculations used to predict the collected enrollment fees. The amount accrued in enrollment fees is exempt from the federal match, so this amount is subtracted from the estimated CHP+ expenditures that can receive

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a federal match for fund split calculations seen in exhibits C2 and C5 (pages S-3A, BA-3.C2-1 through S-3A, BA-3.C2-3, S-3A, BA-3.C5-2, and S-3A, BA-3.C5-4).

### **EXHIBIT C6 - ESTIMATE AND REQUEST BY ELIGIBILITY CATEGORY**

Exhibit C6 provides capitation expenditure calculations for the current fiscal year and the request year.

The Department has adopted a methodology based on forecasting a capitation rate, multiplying that rate by monthly caseload, multiplying again by the number of months that the forecasted rate will be in effect, and then adjusting for incurred claims that will be paid in subsequent years as well as for claims from former years that will be paid in the year of the request. The methodology is a zero-based budget tool that allows the Department to examine projected expenditures each year without building in inappropriate assumptions, estimates, or calculations from preceding years.

The forecasted capitation rate is derived from exhibits C8 through C10 and will be presented in more detail below. The caseload is the same as displayed in exhibit C4.

In order to adjust the calculations for cash accounting, the Department makes two adjustments to the calculation: first, the Department subtracts the incurred amount estimated to be paid in subsequent periods; then, the Department adds the claims incurred in prior periods expected to be paid in the forecast period. These adjustments transform the estimated incurred expenditure to a cash-based figure. The basis for these adjustments is described in this narrative below and is shown in the exhibits starting on page S-3A, BA-3.C6-1.

After calculating total expenditure for capitations, the anticipated reconciliation payments for manual enrollments for each fiscal year are estimated and added to total expenditure. The sum of expenditure for capitation payments and reconciliation payments for manual enrollments is the total CBHP Capitation Payments summarized in exhibit C3. Following the addition of projected reconciliation payments for manual enrollments are any applicable bottom-line impacts to expenditure. Details are discussed below in exhibit C7.

### *Actuarially Certified Capitation Rates*

Capitated rates for the health maintenance organizations are required to be actuarially certified and approved by CMS, thus actuarially certified rate increases could reasonably be expected to be good predictors of future costs. As such, the Department used trends on the

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historically certified capitation rates to derive the capitation rate presented in Exhibit C6. The methodology for determining the forecasted capitation rate is the subject of exhibits C8 through C10.

### ***Incurred-but-not-Reported Estimates***

In order to estimate the necessary adjustments to convert the projection to a cash basis, the Department estimates monthly incurred-but-not-reported (IBNR) adjustments based on historical data. Monthly adjustments are required because, for example, claims incurred in July of the current fiscal year have 11 more months of the fiscal year in which the claims can be paid; however, claims incurred in June of the fiscal year only have the remainder of that month in which to be paid before the payment becomes part of the next fiscal year's expenditure.

The Department examined historical data from the last five fiscal years and determined the prior fiscal years would provide a representative model for the likelihood of claims being paid in the year in which they are incurred. Page S-3A, BA-3.C6-4 presents the percentage of claims paid in a twelve-month period that come from that same period and those which come from previous periods.

### **EXHIBIT C7 - CHILDREN'S BASIC HEALTH PLAN BOTTOM LINE IMPACTS TO EXPENDITURE**

#### *Reconciliation payments for manual enrollments*

As mentioned above, the Department makes reconciliation payments for clients that were manually enrolled. These are projected by applying growth rates from projected caseload (exhibit C4) and rate inflation (exhibit C9) to the expenditure for reconciliation payments for manual enrollments in the previous fiscal year.

#### *Payments to Federally Qualified Health Centers (FQHCs)/ Rural Health Centers (RHCs)*

The Department began making reconciliation payments to FQHCs/RHCs in FY 2013-14, referred to as CHP+ PPS Implementation in the February 2014 request. Services at FQHCs and RHCs are now taken into consideration in the rate setting process as of FY 2014-15, but there are still reconciliation payments to be made. In FY 2015-16, the Department paid \$1,563,307 in reconciliation payments to FQHCs and RHCs for prior years. In FY 2016-17, The Department expects to pay \$907,641 for FQHC/RHC reconciliations and does not expect to pay or recoup any funds thereafter.

#### *Payment for clients that were incorrectly dis-enrolled from CBHP and enrolled into Medicaid*

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Clients were incorrectly dis-enrolled from CBHP in the first half of FY 2015-16 and enrolled into Medicaid under an individual with disabilities eligibility determination. It was determined that this should not have taken place and system issues are being corrected to get all members properly enrolled. As a result of this issue, some HMOs did not receive capitation payments for clients that should have been enrolled. Therefore, the Department expects to make payments of an estimated \$1,857,191 in FY 2016-17 to reconcile. Please see caseload narrative for more detail on this issue.

### **EXHIBIT C8 - CBHP RETROACTIVITY ADJUSTMENT AND CLAIMS DISTRIBUTION ADJUSTMENT MULTIPLIER**

Capitations are paid for clients from the date the client's eligibility is effective, resulting in claims paid retroactively. As such, any projection which derives expenditure by using non-retroactive caseload must take into account these retroactive claims. Since expenditures are calculated as the estimated capitation rate multiplied by the non-retroactive caseload, an adjustment for retroactivity can be applied to either the forecasted capitation rate or the caseload figure. In order to maintain the uniform presentation of caseload across all Departmental estimates and requests, the Department chose to make its retroactivity adjustment to the forecasted capitation rate itself.

Additionally, claims-based data (as it is derived from literally the money spent on each claim) is the actual driver of expenditure. Examining the capitation rate for forecasting allows the Department and policy makers to see the relationship of the capitation payments paid to the health maintenance organizations (HMOs) and State Managed Care Network (SMCN) to total expenditure. Forecasting based on trends in the capitation rate will only be as accurate as the relationship between that capitation trend and any trends in the rates of per-claim expenditure. These two rates can trend similarly, but any difference in trends needs to be captured in order to ensure the accuracy of the forecast. The different trends are usually related to the incidence of payments for partial months of eligibility, which fluctuate for reasons unrelated to the CBHP Capitation program. This difference is captured through a partial-month adjustment multiplier.

#### ***Retroactivity Adjustment Multiplier***

For the purpose of adjusting the forecasted capitation rate to capture the omission of retroactivity from caseload, the Department analyzed the last seven years of claims and caseload data. Page S-3A, BA-3.C8-1 presents the average monthly claims as compared to the average monthly caseload for those years across eligibility categories. The Department did experience a significant amount of duplicate claims through calendar year 2013, but these duplicate claims have been removed from this analysis. Historically, the Department's methodology for calculating the retroactivity factor was to use claims and caseload data for each cohort (i.e. Children to 205% FPL Medical, Children to 205% FPL Dental, Children 206%-260% FPL Medical, etc.), but due to trouble identifying a subset of the population, 201%-205% FPL, retroactivity is skewed. As a result, the new methodology used is to calculate an aggregate

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retroactivity factor based on all children for medical and dental, and all prenatal adults across all FPL groups and use that single factor for both FPL groups for children and prenatal women. Details on the selected retroactivity adjustment can be found on page S-3A, BA-3.C8-1.

### ***Claims Distribution Adjustment Multiplier***

To derive the claims distribution adjustment multiplier for the purpose of capturing any difference in trends between the capitation rate trends and the trends on per-claim expenditure, the last seven years of data were examined.

As presented on page S-3A, BA-3.C8-2, for each eligibility category, the amount paid divided by claims was compared to the weighted capitation rate (weighted by proportion of total claims within an eligibility category covered by an individual HMO or SMCN). Then, the claims-based rate as a percentage of the capitation rate was calculated, providing a simple comparison of any trend in claims-based rates as compared to capitation rates. Details on the selected claims distribution adjustment for each eligibility can be found on page S-3A, BA-3.C8-2.

### **EXHIBIT C9 - CBHP CAPITATION RATE TRENDS AND FORECASTS**

As presented above, the expenditure forecast was derived by examining the trend on the capitation rate and then applying that trend to the monthly cost per client (i.e., the claims-based rate). For the purpose of trend analysis, the weighted capitation rate (weighted by proportion of total claims within an eligibility category covered by an individual health maintenance organization or state managed care network) was examined. Exhibit C9 presents historical data as well as the forecasted weighted rates. Rates are first presented by poverty level and age group, and then aggregated by poverty level for all ages.

The weighted rate is presented along with the percentage change from the previous fiscal year. The multiple forecast trend models and the criteria for selecting the forecasted capitation rate point estimate are presented in Exhibit C10.

Based on the Department's calculations and rate-setting process and input from the health maintenance organizations, the Department's actuaries certify a capitation rate range for each HMO, SMCN, and eligibility type; the Department is permitted to pay any rate within this range and maintain an actuarially sound capitation payment. To develop the range, the actuaries calculate a single rate (the "point estimate") and the upper and lower bounds around this rate that maintain actuarial soundness.

It is important to note the overall weighted point estimate presented in the exhibit is weighted across several factors. First, the rate is weighted within an eligibility category. Within an eligibility category, the rate is weighted by the health maintenance organizations' and

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state managed care network's proportion of claims processed within that eligibility category, the proportion attributable to each FPL category (0%-100%, 101%-150%, 150%-200%, and above 200%), and for children the proportion for each age range (ages 0-1, 2-5, and 6-18). Next, that rate is then weighted across all eligibility categories (with the weight derived from the total number of claims processed within an eligibility category as a percentage of total claims processed across all eligibility categories). Because caseload can be increasing or decreasing independently of any one capitation rate, the weighted CBHP total rate may not be a clear indicator of the rate trends across all eligibility categories.

Exhibit C9 presents the weighted point estimate rates, and the trend of those rates is used for forecasting. The weighted point estimates differ from paid rates, which can change within the upper and lower bounds of the established rate range in response to new rate-setting processes and budget reduction measures. The paid rates, which are discussed below, are not presented in Exhibit C6 in order to allow for comparison across years and so as to not artificially inflate or deflate the rate trend and bias the estimated rate in future years. Below is a table showing the actual weighted rate for FY 2015-16, and the projected weighted rates through FY 2018-19.

<b>Fiscal Year</b>	<b>Children Medical to 205% FPL</b>	<b>Children Medical 206%- 259% FPL</b>	<b>Children Dental to 205% FPL</b>	<b>Children Dental 206%- 259% FPL</b>	<b>Prenatal to 205% FPL</b>	<b>Prenatal 206%- 259% FPL</b>	<b>Weighted CBHP Total</b>
<b>FY 2015-16 Actuals</b>	<b>\$142.91</b>	<b>\$140.61</b>	<b>\$19.25</b>	<b>\$18.78</b>	<b>\$980.40</b>	<b>\$970.08</b>	<b>\$197.68</b>
<b>FY 2016-17 Estimated Rate</b>	<b>\$156.69</b>	<b>\$158.13</b>	<b>\$20.46</b>	<b>\$19.26</b>	<b>\$979.99</b>	<b>\$970.08</b>	<b>\$205.19</b>
% Change from FY 2015-16	9.64%	12.46%	6.29%	2.56%	-0.04%	0.00%	3.79%
<b>FY 2017-18 Estimated Rate</b>	<b>\$159.70</b>	<b>\$163.40</b>	<b>\$21.41</b>	<b>\$20.20</b>	<b>\$1,002.81</b>	<b>\$991.16</b>	<b>\$209.50</b>
% Change from FY 2016-17	1.92%	3.33%	4.64%	4.88%	2.33%	2.17%	2.10%
<b>FY 2018-19 Estimated Rate</b>	<b>\$163.16</b>	<b>\$168.54</b>	<b>\$22.41</b>	<b>\$20.96</b>	<b>\$1,021.11</b>	<b>\$1,008.20</b>	<b>\$214.30</b>
% Change from FY 2017-18	2.17%	3.15%	4.67%	3.76%	1.82%	1.72%	2.29%

**EXHIBIT C10 - FORECAST MODEL COMPARISONS**

Exhibit C10 produces the final capitation rate estimates that are used as the source of the expenditure calculations provided in exhibit C6. Pages S-3A, BA-3.C10-1 and S-3A, BA-3.C10-2 present the final rate estimates in their entirety. The final rate estimates are a product of model selection (discussed below) and the necessary adjustments as presented in exhibit C8.

On page S-3A, BA-3.C10-2, a series of forecast models are presented for each eligibility category. From the models or from historical changes, a point estimate is selected as an input into page S-3A/BA-3.C10-1. Based on the point estimates, the adjustments presented in Exhibit C8 are then applied and the final, adjusted point estimate is then used in the expenditure calculations of exhibit C6.

***Final Forecasts***

Page S-3A, BA-3.C10-1 begins by presenting the known rates from those already set through the actuarial process and the remaining point estimates of each eligibility category's rate as selected on page S-3A, BA-3.C10-2 (see below).

The forecasted rate is then adjusted by the claims distribution adjustment multiplier, calculated on page S-3A, BA-3.C8-2. The multiplier is applied to account for the distribution of clients amongst the different HMO's and the SMCN. The average amount paid may not perfectly reflect the estimated claims distribution. Therefore, the multiplier is applied to convert capitation rates to a figure which is more likely to reflect actual expenditure.

Then the claims-based rate is adjusted a second time, this time by the retroactivity adjustment. From exhibit C8, page S-3A, BA-3.C8-1, this second adjustment is made to capture the retroactivity not captured by the caseload figures. As described in the narrative for exhibit C8, since caseload does not capture retroactivity, and since projected total expenditure is equal to caseload times the projected rate, either the rate or the caseload must be adjusted to capture retroactivity. To keep CBHP caseload matched to other caseload figures presented by the Department, the adjustment is made to the projected rate yielding the final forecasted rate, which is the rate used to derive the expenditure calculation presented in exhibit C6. A similar methodology is applied to the rates in each eligibility category and for each fiscal period.

***Capitation Trend Models***

The forecasted capitation rates are the result of a point estimate selection from among several forecast trend models and historical information. These models are presented on page S-3A, BA-3.C10-2.

For each eligibility category, four different trend model forecasts were performed: an average growth model, a two-period moving average model, an exponential growth model, and a linear growth model. The average growth model examines the rate of change in the capitation rate and applies the average rate of change to the forecast period. The two-period moving average model projects the forecast period will see a change in the capitation rate that is the average of the last two changes in the capitation rate. The exponential growth model assumes the capitation rate is increasing faster as time moves forward (a best-fit exponential equation is applied to the historical data and trended into the future). The linear growth model is a regression model on time, fitting a linear equation line to the historical data and forecasting that line into the future. Each model in the exhibit also shows what the percent change would be from the prior period.

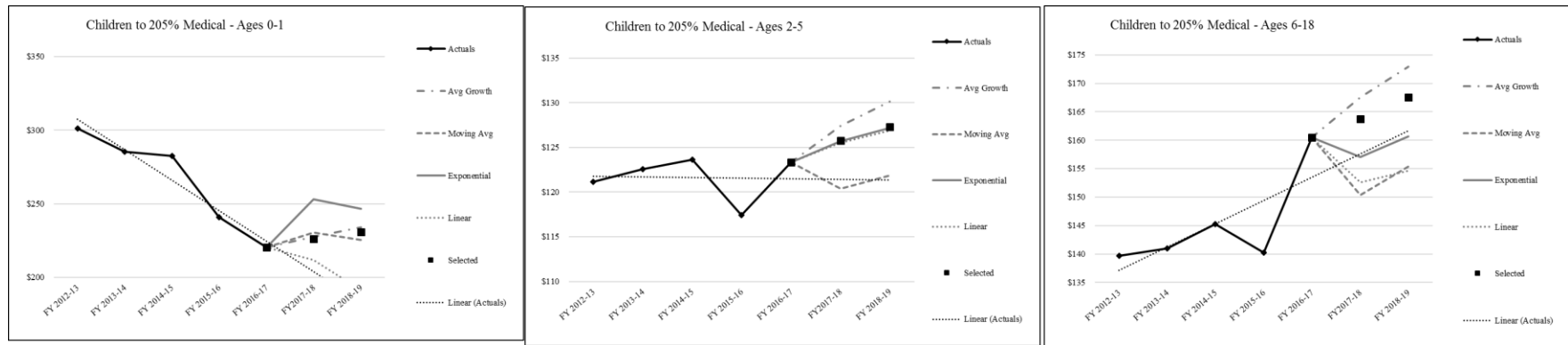
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The Department's decisions for trend factors are informed, in part, by preliminary calculations from the actual rate setting process. Because those calculations remain preliminary, the Department does not explicitly use them in estimating trend factors.

Capitation rates are required to be actuarially sound and are built from a blend of historical rates. The trends models, as presented in this exhibit, are an attempt to predict the final outcome of this rate setting process. However, the use of historical, final rates as data points for predicting future rates is limited when future periods are likely to be fundamentally different than historical periods. The Department has used the trend models to establish a range of reasonable rate values and has selected trends by considering the various factors that impact the respective eligibility populations as well as the impact that encounter data will have on the rate setting process. The tables beginning on the next page show the trends selected for the current and request years by eligibility category.

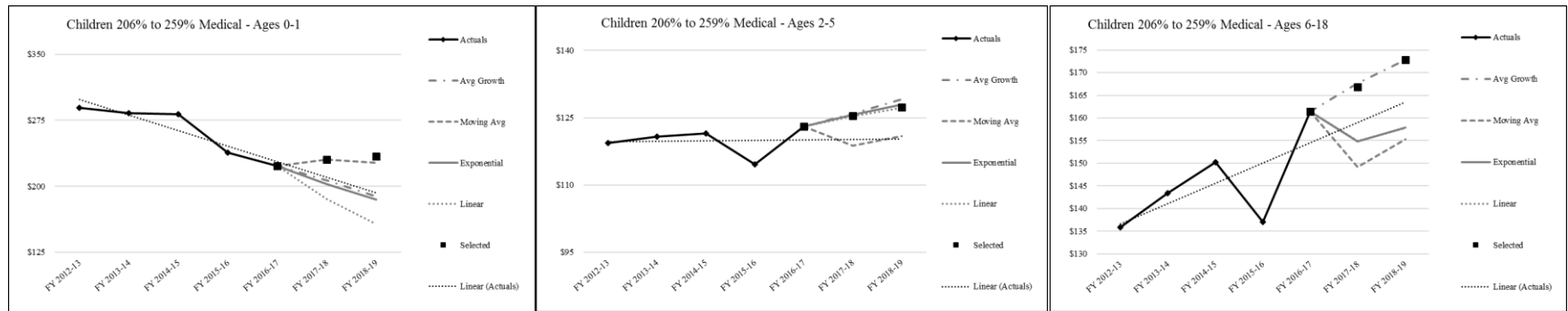
Rate Trends for Children Medical to 205% FPL			
Aid Category	FY 2017-18 Trend Selection	FY 2018-19 Trend Selection	Justification
Children to 205% FPL Medical Ages 0-1	<b>2.32%</b>	<b>2.32%</b>	Rates for clients ages 0-1 decreased in FY 2016-17. The trend selected is only slightly positive.
	½ Two Period Moving Average Model	Trend selected for FY 2017-18	
Children to 205% FPL Medical Ages 2-5	<b>1.91%</b>	<b>1.19%</b>	Rates for clients ages 2-5 increased in FY 2016-17. The trend selected is comparable to the growth in rates seen in FY 201-15 and FY 2016-17.
	Exponential Growth Model	Exponential Growth Model	
Children to 205% FPL Medical Ages 6-18	<b>1.91%</b>	<b>1.19%</b>	Rates for clients ages 6-18 increased significantly in FY 2016-17. In prior years, the rates have been volatile. The trend selected is equal to that of the 2-5 age group.
	Exponential Growth Model of Ages 2-5.	Exponential Growth Model	

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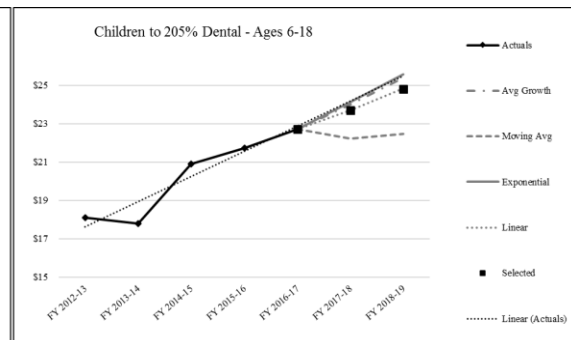
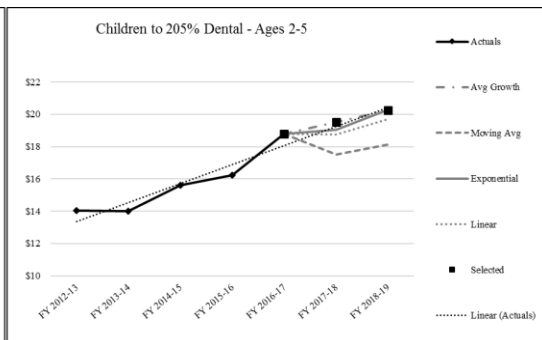
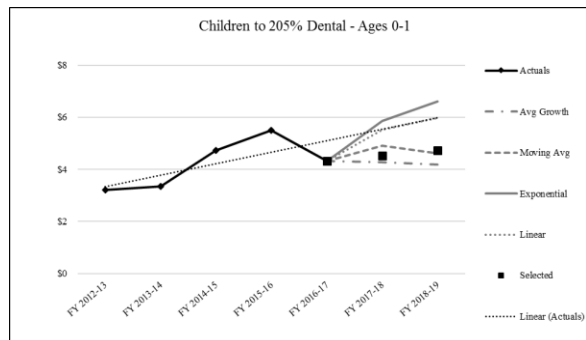
Rate Trends for Children Medical 206% to 260% FPL			
Aid Category	FY 2017-18 Trend Selection	FY 2018-19 Trend Selection	Justification
Children 206% to 260% FPL Medical Ages 0-1	<b>3.31%%</b>	<b>1.66%</b>	Rates for clients ages 0-1 decreased in FY 2016-17. The trend selected is only slightly positive.
	Two Period Moving Average	½ trend selected for FY 2017-18.	
Children 206% to 260% FPL Medical Ages 2-5	<b>1.85%</b>	<b>1.55%</b>	Rates for clients ages 2-5 decreased in FY 2015-16. The trend selected is comparable to the growth in rates in FY 2013-14 and FY 2014-15.
	Linear Growth Model	Linear Growth Model	
Children 206% to 260% FPL Medical Ages 6-18	<b>3.71%</b>	<b>3.71%</b>	Rates for clients ages 6-18 increased in FY 2016-17. In prior years the rates have been volatile. The trend selected is the average of growth in FY 2015-16 and FY 2016-17.
	½ growth from FY 2014-15 to FY 2015-16.	Trend selected for FY 2017-18.	

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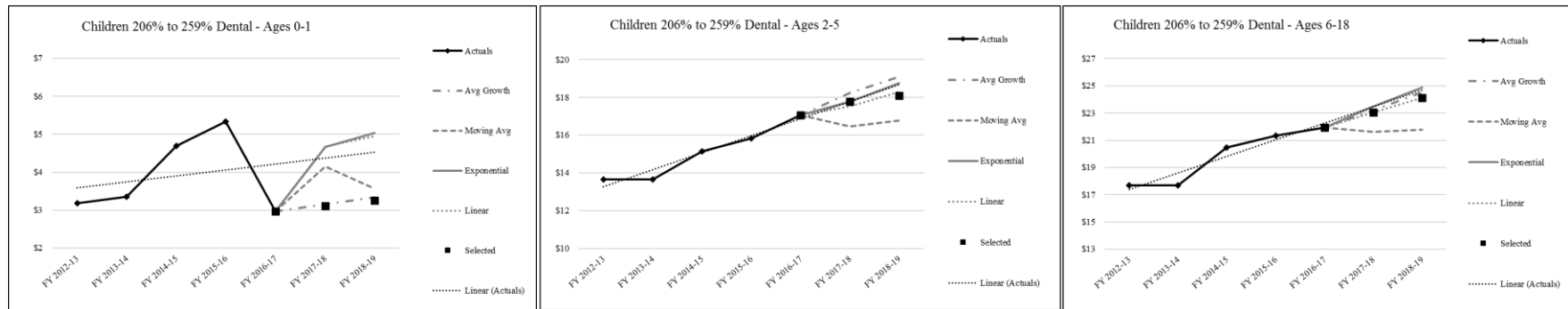
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Rate Trends for Children Dental to 205% FPL			
Aid Category	FY 2017-18 Trend Selection	FY 2018-19 Trend Selection	Justification
Children to 205% FPL Dental Ages 0-1	<b>3.95%</b>	<b>3.95%</b>	The sharp decline seen in FY 2016-17 is due to an expansion in dental benefits for CHP+ with full data. The Department expects these decreases to slow now that the new benefit package has been available for two years.
	½ growth from FY 2014-15 to FY 2016-17.	Trend selected for FY 2017-18.	
Children to 205% FPL Dental Ages 2-5	<b>4.17%</b>	<b>3.74%</b>	The sharp increase seen in FY 2014-15 is due to an expansion in dental benefits for CHP+. There was another increase in FY 2015-16. Rates have stabilized in FY 2016-17.
	Growth from FY 2014-15 to FY 2015-16	Average Growth Model	
Children to 205% FPL Dental Ages 6-18	<b>4.38%</b>	<b>4.74%</b>	The sharp increase seen in FY 2014-15 is due to an expansion in dental benefits for CHP+. There was another increase in FY 2015-16. The Department expects these increases to slow now that the new benefit package has been available for two years.
	Linear Growth Model	Linear Growth Model	



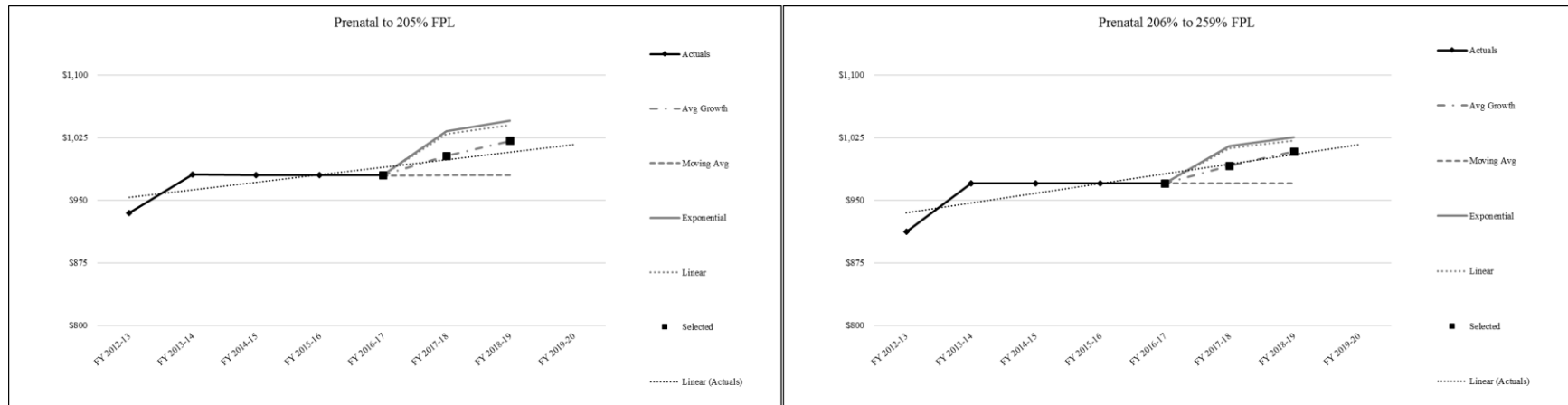
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Rate Trends for Children Dental 206% to 260% FPL			
Aid Category	FY 2017-18 Trend Selection	FY 2018-19 Trend Selection	Justification
Children 206% to 260% FPL Dental Ages 0-1	<b>3.95%</b>	<b>3.95%</b>	The sharp decline seen in FY 2016-17 is due to an expansion in dental benefits for CHP+ with full data. The Department expects these decreases to slow now that the new benefit package has been available for two years.
	Trend selected for Children 0%-205% FPL	Trend selected for Children 0%-205% FPL	
Children 206% to 260% FPL Dental Ages 2-5	<b>4.11%</b>	<b>1.87%</b>	The sharp increase seen in FY 2014-15 is due to an expansion in dental benefits for CHP+. There was another increase in FY 2015-16. The Department expects these increases to slow now that the new benefit package has been available for two years.
	Growth from FY 2014-15 to FY 2015-16	Average Growth Model	
Children 206% to 260% FPL Dental Ages 6-18	<b>5.03%</b>	<b>4.57%</b>	The sharp increase seen in FY 2014-15 is due to an expansion in dental benefits for CHP+. There was another increase in FY 2015-16. The Department expects these increases to slow now that the new benefit package has been available for two years.
	Linear Growth Model	Linear Growth Model	



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Rate Trends for Prenatal			
Aid Category	FY 2017-18 Trend Selection	FY 2018-19 Trend Selection	Justification
Prenatal to 205% FPL	<b>2.33%</b>	<b>1.82%</b>	Rates for prenatal clients did not change from FY 2013-14 through FY 2016-17. The trend selected is slightly positive.
	Average Growth Model	Average Growth Model	
Prenatal 206%-260% FPL	<b>2.17%</b>	<b>1.72%</b>	Rates for prenatal clients did not change from FY 2013-14 through FY 2016-17. The trend selected is slightly positive.
	Average Growth Model	Average Growth Model	



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**CBHP CASELOAD**

***Length of Stay***

CBHP caseload is not only affected by the number of individuals served but also the length of time they remain in the program. The Department has started tracking the average length of stay for each eligibility category to further understand the behavior of the CHP+ clients. Results for FY 2014-15 (shaded) is subject to change as there may not be sufficient run out to capture the true length of stay for all clients. The Department anticipates an increase in the average length of stay as continuous eligibility for Medicaid Eligible Children and CHP+ Children was implemented March 1<sup>st</sup>, 2014.

		<b>CHP Children 0%-205%</b>	<b>CHP Children 206%-260%</b>	<b>CHP Prenatal 0%-205%</b>	<b>CHP Prenatal 206%-260%</b>
FY 2010-11	Avg. LOS Mo's	11.55	12.83	6.96	6.82
	% > 12 Mo's	40.92%	51.30%	1.94%	1.68%
FY 2011-12	Avg. LOS Mo's	9.18	11.26	6.35	6.38
	% > 12 Mo's	32.86%	49.21%	1.41%	0.91%
FY 2012-13	Avg. LOS Mo's	8.53	11.37	5.19	6.35
	% > 12 Mo's	26.63%	42.59%	0.84%	0.62%
FY 2013-14	Avg. LOS Mo's	11.62	13.34	5.29	6.61
	% > 12 Mo's	37.13%	47.16%	1.33%	3.48%
FY 2014-15	Avg. LOS Mo's	13.04	13.08	6.88	6.84
	% > 12 Mo's	48.43%	48.41%	1.49%	1.25%

### ***CBHP Caseload Models***

The Department's caseload projections utilize statistical forecasting methodologies to predict CBHP caseload by eligibility category. Historical monthly caseload data is used from July 2007 to December 2016. The following forecasting models are used to forecast CBHP caseload: trend and monthly seasonal dummy variables, ARIMA models, trend stationary, and difference stationary. The Department is now using the software EViews 6 to estimate these models.

#### ***Trend and Seasonality Model***

CBHP caseload is a non-stationary series with a positive trend and many of the categories experience some level of seasonality. One of the models used incorporates a time trend and monthly seasonal dummy variables.

#### ***ARIMA Model***

ARIMA models, once referred to as Box-Jenkins models, rely on the past behavior of the series being forecasted. Relying on the past behavior of a series mandates that a series be stationary. Most of the eligibilities in Medicaid caseload have a positive growth trend (non-stationary) and require differencing to be made stationary.

#### ***Trend Stationary and Difference Stationary***

Series that are stationary have a constant mean, caseload series frequently do not have this characteristic and often have a trending mean. Two popular models used for non-stationary series with a trending mean are trend stationary and difference stationary. The trend stationary serves as an effective model if the series has a deterministic trend. The difference stationary model proves effective should the trend be stochastic. Differencing the dependent variable gives a stationary series. The basic forms of the two models are listed below.

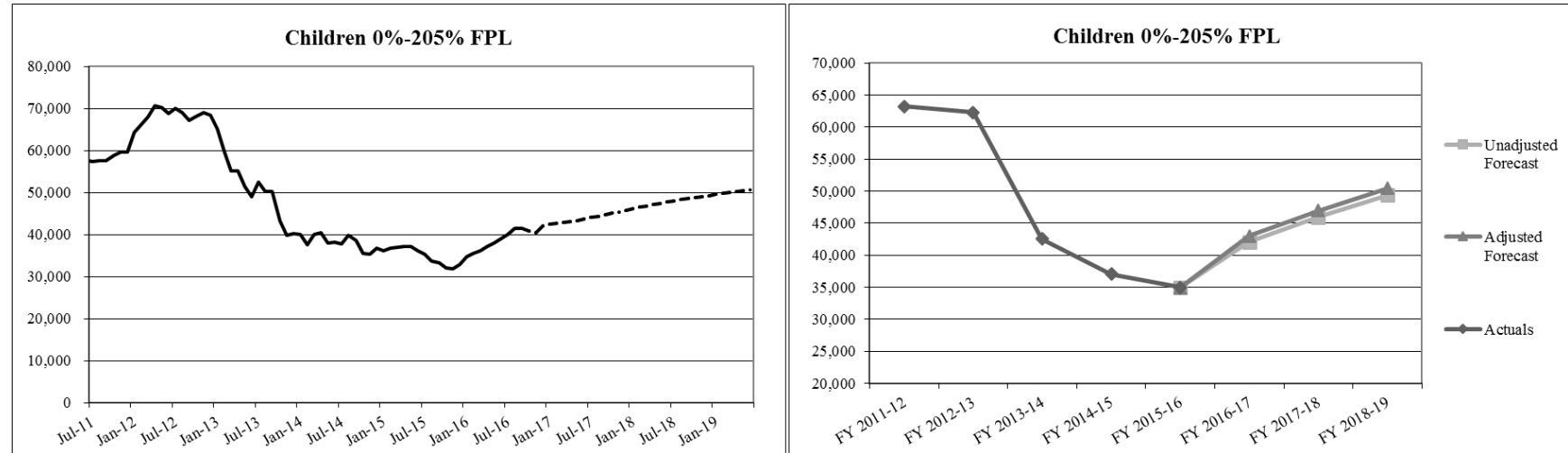
- Trend Stationary:  $\log(y) = c + \text{trend} + \epsilon$
- Difference Stationary:  $\text{differenced}(\log(y)) = c + \epsilon$

### ***Model Selection***

Models are created for each individual group that receives a separate rate. These groups are separated by FPL for both children and prenatal: under 100%, 101%-150%, 151%-200%, 201%-205%, and 206%-260%. Children's groups are also separated by age: age groups 0-1, 2-5, and 6-18. A model is selected to forecast each group. After several different forecasts are produced, the Department normally chooses one for each category and then aggregates to the FPL categories for children and prenatal; under 205% and 206%-260%. When selecting a model, the Department closely analyzes the historical data as well as the goodness of fit of the model.

**CHILDREN'S BASIC HEALTH PLAN CASELOAD FORECAST**

*Children's Caseload Projections (Exhibit C4)*



- Monthly caseload for December for CHP+ Children 0%-205% FPL was 41,974, which was higher than what was forecasted in the November 2016 forecast by 1,112. If caseload for this group remained at this level for the remainder of the fiscal year, FY 2016-17 caseload would grow by roughly 20%. The Department does expect some growth in the second half of the year, projecting final FY 2016-17 average monthly caseload of 43,020, or an increase of 23.13% over FY 2015-16. The Department expects moderate caseload growth in FY 2017-18 and FY 2018-19 as a result of the improving economy and slowing growth in Medicaid caseload for children.
- This population includes the subpopulation created through SB 07-097, and was implemented beginning March 1, 2008. Children in this population have family incomes between 201% and 205% FPL.
  - This population is identified with an income rating code that represented 201%-205% FPL. After the MAGI conversion, this income rating code changed from 201%-205% to 201%-213%. The Department is working to identify a discrete FPL for CHP+ clients, but until that option is available a distribution of clients over 200% FPL prior to January 2014 is being used to estimate the clients that are between 201%-205% and 206%-260% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.

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- There is one bottom-line adjustment to the Children to 205% FPL caseload. It is the projected impact from the continued implementation of HB 09-1353, which removes the five year bar on legal immigrant children and pregnant adults. This five year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department implemented this for CHP+ children in FY 2015-16.

## Page S-3A, BA-3.25

Children 0% -205% FPL: Historical Caseload and Projections

	Actuals	Monthly Change	% Change		Caseload	% Change	Level Change
Dec-14	36,771	-	-	FY 2008-09	61,582		
Jan-15	36,177	(594)	-1.62%	FY 2009-10	68,589	11.38%	7,007
Feb-15	36,686	509	1.41%	FY 2010-11	63,244	-7.79%	(5,345)
Mar-15	36,909	223	0.61%	FY 2011-12	63,217	-0.04%	(27)
Apr-15	37,175	266	0.72%	FY 2012-13	62,260	-1.51%	(957)
May-15	37,114	(61)	-0.16%	FY 2013-14	42,511	-31.72%	(19,749)
Jun-15	36,236	(878)	-2.37%	FY 2014-15	37,032	-12.89%	(5,479)
Jul-15	35,269	(967)	-2.67%	FY 2015-16	34,940	-5.65%	(2,092)
Aug-15	33,608	(1,661)	-4.71%	FY 2016-17	42,029	20.29%	7,089
Sep-15	33,333	(275)	-0.82%	FY 2017-18	45,908	9.23%	3,879
Oct-15	32,011	(1,322)	-3.97%	FY 2018-19	49,347	7.49%	3,439
Nov-15	31,821	(190)	-0.59%				
Dec-15	32,921	1,100	3.46%				
Jan-16	34,658	1,737	5.28%				
Feb-16	35,557	899	2.59%				
Mar-16	36,075	518	1.46%				
Apr-16	37,075	1,000	2.77%				
May-16	38,019	944	2.55%				
Jun-16	38,938	919	2.42%				
Jul-16	39,962	1,024	2.63%				
Aug-16	41,345	1,383	3.46%				
Sep-16	41,419	74	0.18%				
Oct-16	40,916	(503)	-1.21%				
Nov-16	40,451	(465)	-1.14%				
Dec-16	41,974	1,523	3.77%				

November 2016 Projection Before Adjustments			
FY 2015-16	34,940	-5.65%	(2,092)
FY 2016-17	40,031	14.57%	5,091
FY 2017-18	40,800	1.92%	769
FY 2018-19	41,734	2.29%	934

HB 09-1353 Adjustment	
FY 2015-16	-
FY 2016-17	991
FY 2017-18	1,026
FY 2018-19	1,050

February 2017 Projections After Adjustments			
FY 2015-16	34,940	-5.65%	(2,092)
FY 2016-17	43,020	23.13%	8,080
FY 2017-18	46,934	9.10%	3,914
FY 2018-19	50,397	7.38%	3,463

Actuals		
	Monthly Change	% Change
6-month average	506	1.28%
12-month average	754	2.06%
18-month average	319	0.86%
24-month average	217	0.58%

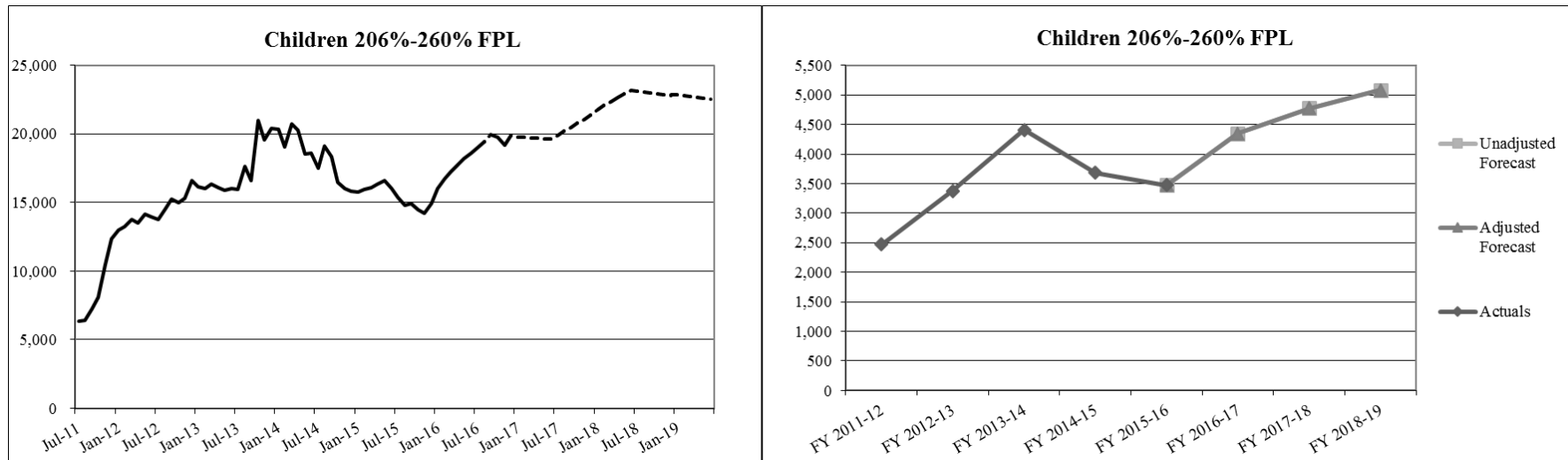
November 2016 Projection After Adjustments			
FY 2015-16	34,940	-5.65%	(2,092)
FY 2016-17	41,022	17.41%	6,082
FY 2017-18	41,826	1.96%	804
FY 2018-19	42,784	2.29%	958

Monthly Average Growth Comparisons		
FY 2015-16 Actuals	225	0.65%
FY 2015-16 1st Half	(553)	-1.55%
FY 2015-16 2nd Half	1,003	2.84%
FY 2016-17 1st Half Actuals	506	1.28%
FY 2016-17 2nd Half Forecast	873	1.98%
FY 2016-17 Forecast	689	1.63%
November 2016 Forecast	321	0.79%
FY 2017-18 Forecast	(43)	-0.09%
November 2016 Forecast	(148)	-0.34%

November 2016 Forecast			
Forecasted December 2016 Level			40,862

Base trend from December 2016 level			
FY 2016-17	41,974	20.13%	7,034

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- Monthly caseload for December for CHP+ Children 206%-260% FPL was 19,860, which was higher than what was forecasted in the November 2016 forecast by 241. If caseload for this group remained at this level for the remainder of the fiscal year, FY 2016-17 caseload would grow by roughly 22%. The Department does expect some growth in the second half of the year, projecting final FY 2016-17 average monthly caseload of 20,109, or an increase of 24,90% over FY 2015-16. The Department expects moderate caseload growth in FY 2017-18 and FY 2018-19 as a result of the improving economy and slowing growth in Medicaid caseload for children.
- This population was created through HB 09-1293, and was implemented beginning May 1, 2010. Children in this population have family incomes between 206% and 260% of the federal poverty level.
- After the MAGI conversion, an income rating code used to identify clients from 201%-205% changed to 201%-213%. The Department is working to identify a discrete FPL for CHP+ clients, but until that option is available a distribution of clients over 200% FPL prior to January 2014 is being used to estimate the clients that are between 201%-205% and 206%-259% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.
- There is one bottom-line adjustment to the Children 206%-260% FPL caseload. It is the projected impact from the continued implementation of HB 09-1353, which removes the 5 year bar on legal immigrant children and pregnant adults. This five year bar was originally removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department

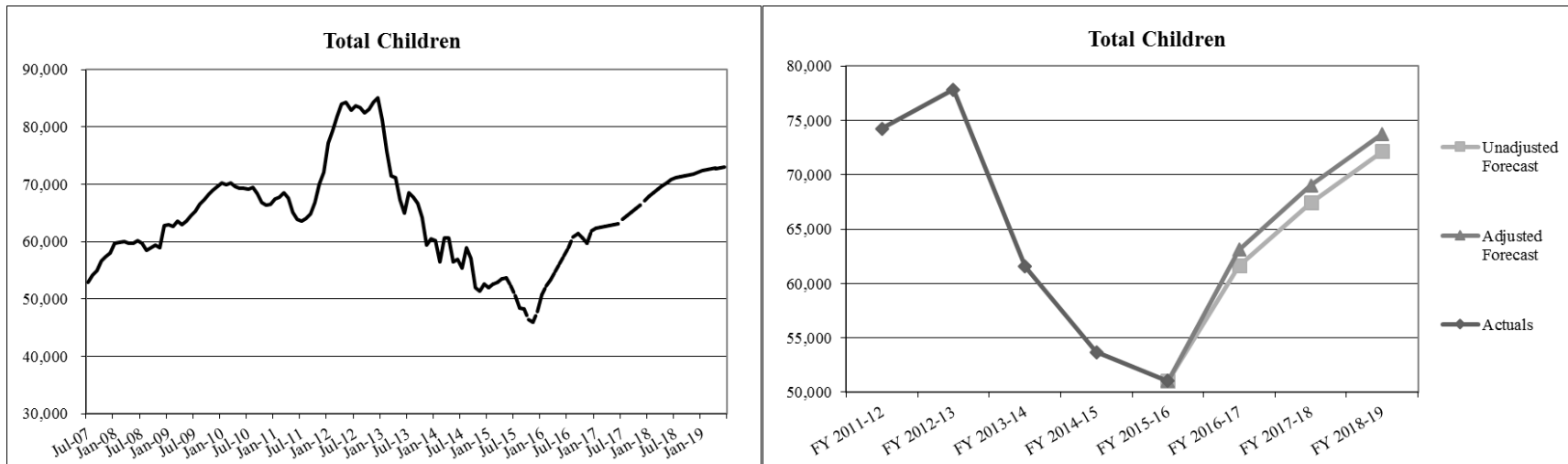
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implemented this for CHP+ children in FY 2015-16. The original calculation estimated an impact only for clients under 200%. The Department has changed this assumption and believes that the implementation of HB 09-1353 affects all FPL categories in CHP+.

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Children 206% -260% FPL: Historical Caseload and Projections									
	Actuals	Monthly Change	% Change		Caseload	% Change	Level Change		
Dec-14	15,851	-	-	FY 2010-11	4,023				
Jan-15	15,780	(71)	-0.45%	FY 2011-12	11,049	174.65%	7,026		
Feb-15	15,980	200	1.27%	FY 2012-13	15,575	40.96%	4,526		
Mar-15	16,068	88	0.55%	FY 2013-14	19,043	22.27%	3,468		
Apr-15	16,327	259	1.61%	FY 2014-15	16,668	-12.47%	(2,375)		
May-15	16,573	246	1.51%	FY 2015-16	16,100	-3.41%	(568)		
Jun-15	16,005	(568)	-3.43%	FY 2016-17	19,607	21.78%	3,507		
Jul-15	15,382	(623)	-3.89%	FY 2017-18	21,548	9.90%	1,941		
Aug-15	14,765	(617)	-4.01%	FY 2018-19	22,824	5.92%	1,276		
Sep-15	14,936	171	1.16%						
Oct-15	14,444	(492)	-3.29%						
Nov-15	14,212	(232)	-1.61%						
Dec-15	14,908	696	4.90%						
Jan-16	16,036	1,128	7.57%						
Feb-16	16,728	692	4.32%						
Mar-16	17,257	529	3.16%						
Apr-16	17,763	506	2.93%						
May-16	18,204	441	2.48%						
Jun-16	18,568	364	2.00%						
Jul-16	18,968	400	2.15%						
Aug-16	19,419	451	2.38%						
Sep-16	19,945	526	2.71%						
Oct-16	19,751	(194)	-0.97%						
Nov-16	19,205	(546)	-2.76%						
Dec-16	19,860	655	3.41%						
November 2016 Forecast									
Forecasted December 2016 Level			19,619						
Base trend from December 2016 level									
FY 2016-17	19,860	23.35%	3,760						
				November 2016 Projection Before Adjustments					
				FY 2015-16	16,100	-3.41%	(568)		
				FY 2016-17	19,595	21.71%	3,495		
				FY 2017-18	20,067	2.41%	472		
				FY 2018-19	20,573	2.52%	506		
				HB 09-1353 Adjustment					
				FY 2015-16	-				
				FY 2016-17	502				
				FY 2017-18	529				
				FY 2018-19	542				
				February 2017 Projections After Adjustments					
				FY 2015-16	16,100	-3.41%	(568)		
				FY 2016-17	20,109	24.90%	4,009		
				FY 2017-18	22,077	9.79%	1,968		
				FY 2018-19	23,366	5.84%	1,289		
				Actuals					
					Monthly Change	% Change			
				6-month average	215	1.15%			
				12-month average	413	2.45%			
				18-month average	214	1.26%			
				24-month average	167	0.99%			
				Monthly Average Growth Comparisons					
				FY 2015-16 Actuals	301	1.74%			
				FY 2015-16 1st Half	(183)	-1.12%			
				FY 2015-16 2nd Half	610	3.74%			
				FY 2016-17 1st Half Actuals	215	1.15%			
				FY 2016-17 2nd Half Forecast	238	1.16%			
				FY 2016-17 Forecast	353	1.75%			
				November 2016 Forecast	235	1.25%			
				FY 2017-18 Forecast	(26)	-0.11%			
				November 2016 Forecast	(122)	-0.61%			

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- Monthly caseload for December for CHP+ Children 0%-260% FPL was 61,834, which was higher than what was forecasted in the November 2016 forecast by 1,353. If caseload for this group remained at this level for the remainder of the fiscal year, FY 2016-17 caseload would grow by roughly 21%. The Department does expect some growth in the second half of the year, projecting final FY 2016-17 average monthly caseload of 63,129, or an increase of 23.69% over FY 2015-16. The Department expects moderate caseload growth in FY 2017-18 and FY 2018-19 as a result of the improving economy and slowing growth Medicaid caseload for children.

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Total Children: Historical Caseload and Projections						
	Actuals	Monthly Change	% Change		Caseload	% Change Level Change
Dec-14	52,622	-	-	FY 2008-09	61,582	
Jan-15	51,957	(665)	-1.26%	FY 2009-10	68,725	11.60% 7,143
Feb-15	52,666	709	1.36%	FY 2010-11	67,267	-2.12% (1,458)
Mar-15	52,977	311	0.59%	FY 2011-12	74,266	10.40% 6,999
Apr-15	53,502	525	0.99%	FY 2012-13	77,835	4.81% 3,569
May-15	53,687	185	0.35%	FY 2013-14	61,554	-20.92% (16,281)
Jun-15	52,241	(1,446)	-2.69%	FY 2014-15	53,700	-12.76% (7,854)
Jul-15	50,651	(1,590)	-3.04%	FY 2015-16	51,040	-4.95% (2,660)
Aug-15	48,373	(2,278)	-4.50%	FY 2016-17	61,636	20.76% 10,596
Sep-15	48,269	(104)	-0.21%	FY 2017-18	67,456	9.44% 5,820
Oct-15	46,455	(1,814)	-3.76%	FY 2018-19	72,171	6.99% 4,715
Nov-15	46,033	(422)	-0.91%			
Dec-15	47,829	1,796	3.90%			
Jan-16	50,694	2,865	5.99%			
Feb-16	52,285	1,591	3.14%			
Mar-16	53,332	1,047	2.00%			
Apr-16	54,838	1,506	2.82%			
May-16	56,223	1,385	2.53%			
Jun-16	57,506	1,283	2.28%			
Jul-16	58,930	1,424	2.48%			
Aug-16	60,764	1,834	3.11%			
Sep-16	61,364	600	0.99%			
Oct-16	60,667	(697)	-1.14%			
Nov-16	59,656	(1,011)	-1.67%			
Dec-16	61,834	2,178	3.65%			

November 2016 Forecast	
Forecasted December 2016 Level	60,481

Base trend from December 2016 level	
FY 2016-17	61,834    21.15%    10,794

**HB 09-1353 Adjustment**

FY 2015-16	-
FY 2016-17	1,493
FY 2017-18	1,555
FY 2018-19	1,592

**February 2017 Projections After Adjustments**

FY 2015-16	51,040	-4.95%	(2,660)
FY 2016-17	63,129	23.69%	12,089
FY 2017-18	69,011	9.32%	5,882
FY 2018-19	73,763	6.89%	4,752

**Actuals**

	Monthly Change	% Change
6-month average	721	1.24%
12-month average	1,167	2.18%
18-month average	533	0.98%
24-month average	384	0.71%

November 2016 Projection Before Adjustments			
FY 2015-16	51,040	-17.08%	(10,514)
FY 2016-17	59,626	16.82%	8,586
FY 2017-18	60,867	2.08%	1,241
FY 2018-19	62,307	2.37%	1,440

HB 09-1353 Adjustment	
FY 2015-16	-
FY 2016-17	1,493
FY 2017-18	1,555
FY 2018-19	1,592

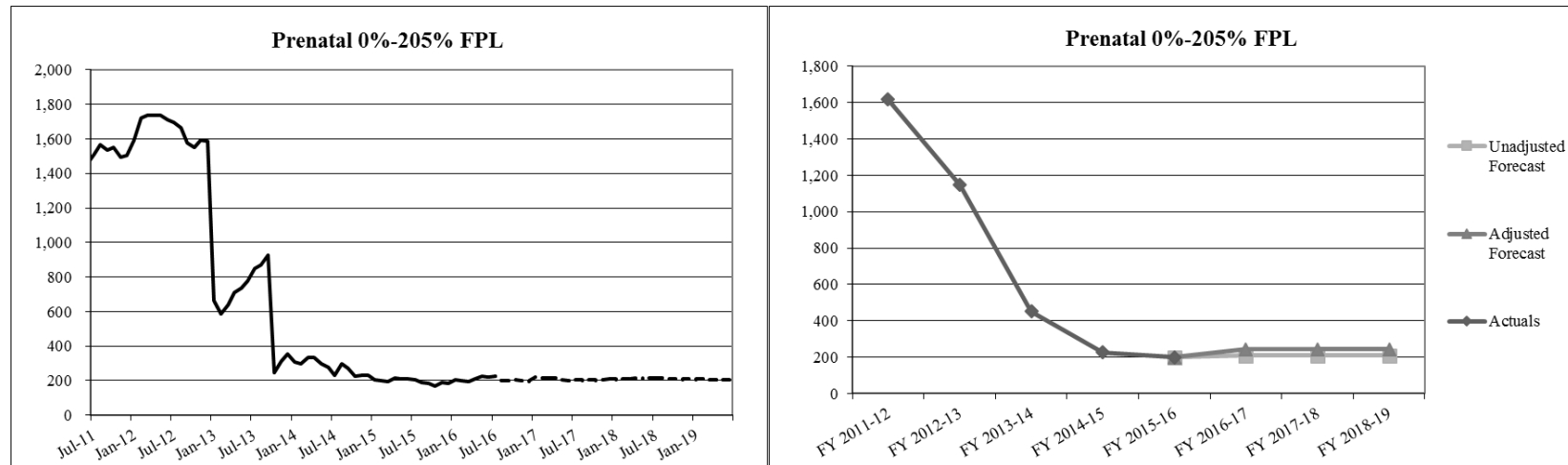
November 2016 Projection After Adjustments			
FY 2015-16	51,040	-17.08%	(10,514)
FY 2016-17	61,119	19.75%	10,079
FY 2017-18	62,422	2.13%	1,303
FY 2018-19	63,899	2.37%	1,477

Monthly Average Growth Comparisons		
FY 2015-16 Actuals	439	0.85%
FY 2015-16 1st Half	(735)	-1.42%
FY 2015-16 2nd Half	1,613	3.13%
FY 2016-17 1st Half Actuals	721	1.24%
FY 2016-17 2nd Half Forecast	1,111	1.72%
FY 2016-17 Forecast	916	1.48%
November 2016 Forecast	556	0.92%
FY 2017-18	21	0.03%
November 2016 Forecast	(270)	-0.43%

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### Prenatal Caseload Projections (Exhibit C4)



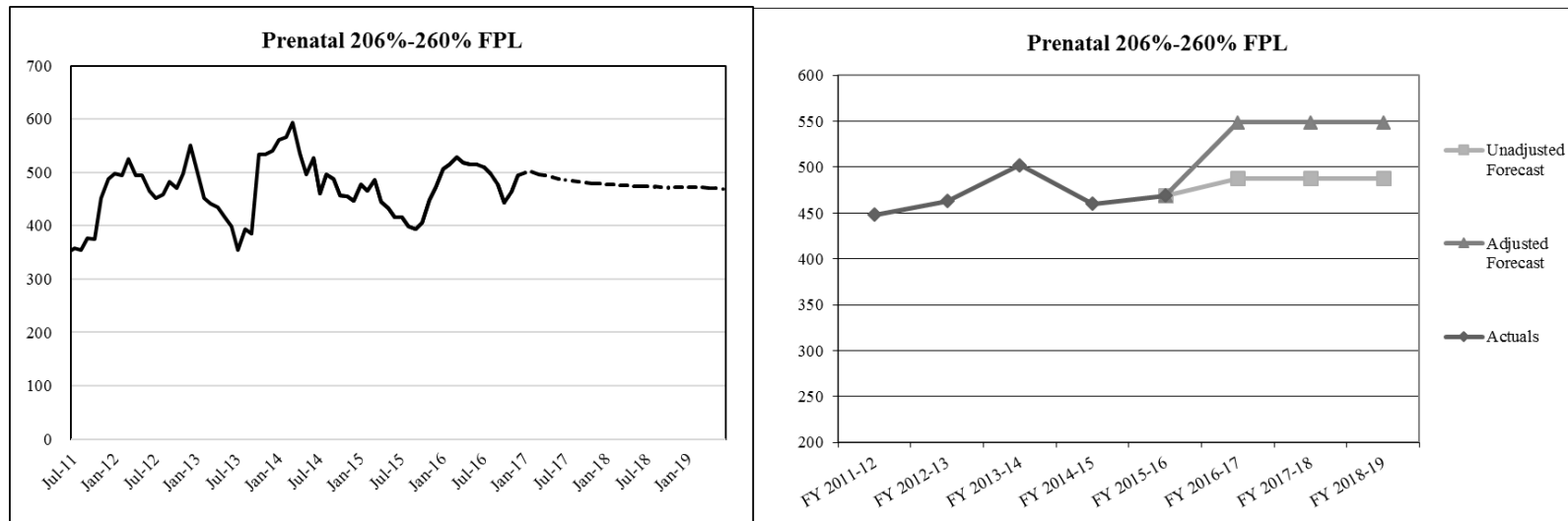
- Monthly caseload for December for CHP+ Prenatal 0%-205% FPL was 199, which was lower than what was forecasted in the November 2016 forecast by 56 clients. The Department does expect some growth in the second half of the year, projecting final FY 2016-17 average monthly caseload of 244, or an increase of 5.03% over FY 2015-16. The Department expects caseload in FY 2017-18 and FY 2018-19 to remain flat.
- Along with the children's expansion to 205% FPL, this population includes the subpopulation that was created through SB 07-097 and was implemented beginning March 1, 2008. Prenatal women in this subpopulation have family incomes between 201 and 205% of the federal poverty level.
  - Similar to children, this population is identified with an income rating code that represented 201%-205% FPL. After the MAGI conversion, this income rating code changed from 201%-205% to 201%-213% FPL. The Department is working to identify a discrete FPL for CHP+ clients, but until that option is available a distribution of clients over 200% FPL prior to January 2014 is being used to estimate the clients that are between 201%-205% and 206%-260% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.
- There is one bottom-line adjustment to the CHP+ prenatal caseload. It is from the continued implementation of HB 09-1353, which removes the five year bar on legal immigrant children and pregnant adults. This 5 year bar was removed for

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pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department implemented this for CHP+ prenatal clients in FY 2015-16.

Prenatal 0% -205% FPL: Historical Caseload and Projections											
	Actuals	Monthly Change	% Change		Caseload	% Change	Level Change				
Dec-14	232	-	-	FY 2008-09	1,665						
Jan-15	205	(27)	-11.64%	FY 2009-10	1,550	-6.91%	(115)				
Feb-15	200	(5)	-2.44%	FY 2010-11	1,470	-5.16%	(80)				
Mar-15	195	(5)	-2.50%	FY 2011-12	1,616	9.93%	146				
Apr-15	214	19	9.74%	FY 2012-13	1,148	-28.96%	(468)				
May-15	212	(2)	-0.93%	FY 2013-14	451	-60.71%	(697)				
Jun-15	210	(2)	-0.94%	FY 2014-15	227	-49.67%	(224)				
Jul-15	206	(4)	-1.90%	FY 2015-16	199	-12.33%	(28)				
Aug-15	189	(17)	-8.25%	FY 2016-17	209	5.03%	10				
Sep-15	183	(6)	-3.17%	FY 2017-18	209	0.00%	0				
Oct-15	167	(16)	-8.74%	FY 2018-19	209	0.00%	0				
Nov-15	192	25	14.97%								
Dec-15	187	(5)	-2.60%								
Jan-16	205	18	9.63%								
Feb-16	202	(3)	-1.46%								
Mar-16	196	(6)	-2.97%								
Apr-16	212	16	8.16%								
May-16	225	13	6.13%								
Jun-16	220	(5)	-2.22%								
Jul-16	227	7	3.18%								
Aug-16	200	(27)	-11.89%								
Sep-16	199	(1)	-0.50%								
Oct-16	204	5	2.51%								
Nov-16	202	(2)	-0.98%								
Dec-16	199	(3)	-1.49%								
November 2016 Forecast											
Forecasted December 2016 Level			255								
Base trend from December 2016 level											
FY 2016-17	199	0.00%	0								
				HB 09-1353 Adjustment							
				FY 2015-16		-					
				FY 2016-17		35					
				FY 2017-18		34					
				FY 2018-19		34					
				February 2017 Projections After Adjustments							
				FY 2015-16		199 -12.33% (28)					
				FY 2016-17		244 5.03% 45					
				FY 2017-18		243 0.00% (1)					
				FY 2018-19		243 0.00% -					
				Actuals							
						Monthly Change		% Change			
				6-month average		(4) -1.53%					
				12-month average		1 0.67%					
				18-month average		(1) -0.09%					
				24-month average		(1) -0.43%					
								November 2016 Projection Before Adjustments			
				FY 2015-16		199 -12.33% (28)					
				FY 2016-17		223 12.06% 24					
				FY 2017-18		226 1.35% 3					
				FY 2018-19		225 -0.44% (1)					
								HB 09-1353 Adjustment			
				FY 2015-16		-					
				FY 2016-17		35					
				FY 2017-18		34					
				FY 2018-19		34					
								November 2016 Projection After Adjustments			
				FY 2015-16		199 -12.33% (28)					
				FY 2016-17		258 12.06% 59					
				FY 2017-18		260 1.35% 2					
				FY 2018-19		259 -0.44% (1)					
								Monthly Average Growth Comparisons			
				FY 2015-16 Actuals		1 0.63%					
				FY 2015-16 1st Half		(4) -1.62%					
				FY 2015-16 2nd Half		6 2.88%					
				FY 2016-17 1st Half Actuals		(4) -1.53%					
				FY 2016-17 2nd Half Forecast		24 9.49%					
				FY 2016-17 Forecast		10 3.98%					
				November 2016 Forecast		6 2.33%					
				FY 2017-18 Forecast		(15) -6.22%					
				November 2016 Forecast		(5) -1.76%					

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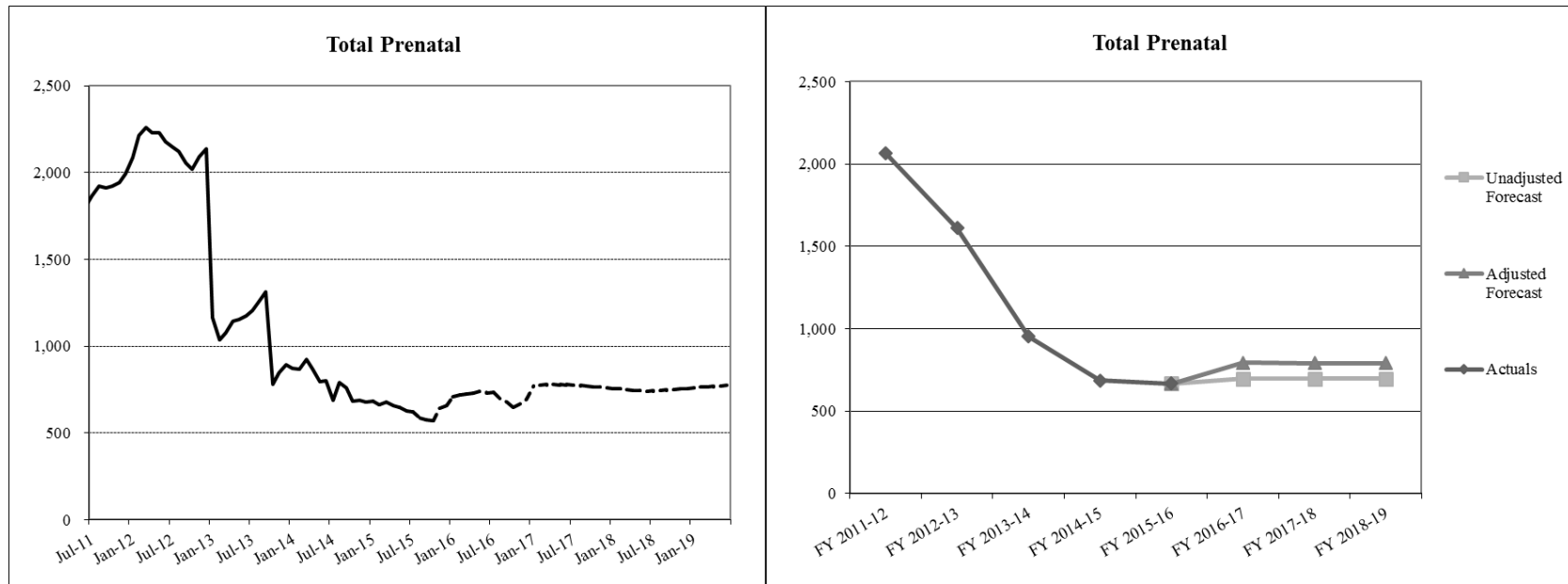


- Monthly caseload for December for CHP+ Prenatal 206%-260% FPL was 494, which was lower than what was forecasted in the November 2016 forecast by 76 clients. The Department does expect some growth in the second half of the year, projecting final FY 2016-17 average monthly caseload of 549, or an increase of 17.06% over FY 2015-16. The Department expects caseload in FY 2017-18 and FY 2018-19 to remain flat.
- This population was created through HB 09-1293, and was implemented beginning May 1, 2010. Pregnant women in this population have family incomes between 206% and 260% of the federal poverty level.
- There is one bottom-line adjustments to the CHP+ prenatal caseload. It is from the continued implementation of HB 09-1353, which removes the five year bar on legal immigrant children and pregnant adults. This 5 year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department implemented this for CHP+ prenatal clients in FY 2015-16. The original calculation estimated an impact only for clients under 200%. The Department has changed this assumption and believes that the implementation of HB 09-1353 affects all FPL categories in CHP+.

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206% -259% FPL Prenatal: Historical Caseload and Projections											
	Actuals	Monthly Change	% Change		Caseload	% Change	Level Change				
Dec-14	446	-	-	FY 2009-10	11						
Jan-15	478	32	7.17%	FY 2010-11	272						
Feb-15	465	(13)	-2.72%	FY 2011-12	448	64.71%	176				
Mar-15	485	20	4.30%	FY 2012-13	463	3.35%	15				
Apr-15	444	(41)	-8.45%	FY 2013-14	502	8.42%	39				
May-15	433	(11)	-2.48%	FY 2014-15	460	-8.37%	(42)				
Jun-15	416	(17)	-3.93%	FY 2015-16	469	1.96%	9				
Jul-15	415	(1)	-0.24%	FY 2016-17	488	4.05%	19				
Aug-15	398	(17)	-4.10%	FY 2017-18	488	0.00%	0				
Sep-15	394	(4)	-1.01%	FY 2018-19	488	0.00%	0				
Oct-15	405	11	2.79%								
Nov-15	449	44	10.86%								
Dec-15	472	23	5.12%								
Jan-16	506	34	7.20%								
Feb-16	515	9	1.78%								
Mar-16	529	14	2.72%								
Apr-16	519	(10)	-1.89%								
May-16	515	(4)	-0.77%								
Jun-16	514	(1)	-0.19%								
Jul-16	509	(5)	-0.97%								
Aug-16	497	(12)	-2.36%								
Sep-16	477	(20)	-4.02%								
Oct-16	443	(34)	-7.13%								
Nov-16	464	21	4.74%								
Dec-16	494	30	6.47%								
November 2016 Forecast											
Forecasted December 2016 Level			570								
Base trend from December 2016 level											
FY 2016-17	494	1.23%	6								

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- Monthly caseload for December for CHP+ Prenatal 0%-260% FPL was 693, which was lower than what was forecasted in the November 2016 forecast by 132 clients. The Department does expect some growth in the second half of the year, projecting final FY 2016-17 average monthly caseload of 793, or an increase of 9.58% over FY 2015-16. The Department expects caseload in FY 2017-18 and FY 2018-19 to remain flat.

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Total Prenatal: Historical Caseload and Projections									
	Actuals	Monthly Change	% Change			Caseload	% Change	Level Change	
Dec-14	678	-	-		FY 2008-09	1,665			
Jan-15	683	5	0.74%		FY 2009-10	1,561	-6.25%	(104)	
Feb-15	665	(18)	-2.64%		FY 2010-11	1,742	11.60%	181	
Mar-15	680	15	2.26%		FY 2011-12	2,064	18.48%	322	
Apr-15	658	(22)	-3.24%		FY 2012-13	1,611	-21.95%	(453)	
May-15	645	(13)	-1.98%		FY 2013-14	953	-40.84%	(658)	
Jun-15	626	(19)	-2.95%		FY 2014-15	687	-27.91%	(266)	
Jul-15	621	(5)	-0.80%		FY 2015-16	668	-2.77%	(19)	
Aug-15	587	(34)	-5.48%		FY 2016-17	697	4.34%	29	
Sep-15	577	(10)	-1.70%		FY 2017-18	697	0.00%	0	
Oct-15	572	(5)	-0.87%		FY 2018-19	697	0.00%	0	
Nov-15	641	69	12.06%						
Dec-15	659	18	2.81%						
Jan-16	711	52	7.89%						
Feb-16	717	6	0.84%						
Mar-16	725	8	1.12%						
Apr-16	731	6	0.83%						
May-16	740	9	1.23%						
Jun-16	734	(6)	-0.81%						
Jul-16	736	2	0.27%						
Aug-16	697	(39)	-5.30%						
Sep-16	676	(21)	-3.01%						
Oct-16	647	(29)	-4.29%						
Nov-16	666	19	2.94%						
Dec-16	693	27	4.05%						

November 2016 Projection Before Adjustments			
FY 2015-16	668	-2.77%	(19)
FY 2016-17	737	10.33%	69
FY 2017-18	740	0.41%	3
FY 2018-19	739	-0.14%	(1)

HB 09-1353 Adjustment	
FY 2015-16	-
FY 2016-17	96
FY 2017-18	95
FY 2018-19	95

February 2017 Projections After Adjustments			
FY 2015-16	668	-2.77%	(19)
FY 2016-17	793	9.58%	125
FY 2017-18	792	0.00%	(1)
FY 2018-19	792	0.00%	-

Actuals		
	Monthly Change	% Change
6-month average	(7)	-0.89%
12-month average	3	0.48%
18-month average	4	0.65%
24-month average	1	0.17%

November 2016 Forecast		
Forecasted December 2016 Level		825

Base trend from December 2016 level		
FY 2016-17	693	3.74%
		25

November 2016 Projection After Adjustments		
FY 2015-16	668	-2.77%
FY 2016-17	833	24.70%
FY 2017-18	835	0.24%
FY 2018-19	834	-0.12%

Monthly Average Growth Comparisons		
FY 2015-16 Actuals	9	1.43%
FY 2015-16 1st Half	6	1.00%
FY 2015-16 2nd Half	13	1.85%
FY 2016-17 1st Half Actuals	(7)	-0.89%
FY 2016-17 2nd Half Foreca	9	1.12%
FY 2016-17 Forecast	9	1.16%
November 2016 Forecast	15	1.87%
FY 2017-18 Forecast	(8)	-0.98%
November 2016 Forecast	(13)	-1.49%